Pharmacy

Prior Authorization Criteria for Lidoderm

Background

Lidocaine 5% patch (Lidoderm), is in the topical pain medication class on the DoD Uniform Formulary. Other medications in this class include diclofenac 1% gel (Voltaren), diclofenac 1.5% solution (Pennsaid), and diclofenac 1.3% patch (Flector). After evaluating the relative clinical and cost effectiveness of these agents, the DoD P&T Committee recommended that Lidoderm be subject to prior authorization requirements.

The following criteria were established by the DoD Pharmacy & Therapeutics (P&T) Committee.

Prior Authorization Criteria for New and Current Users of Lidoderm

Manual PA criteria, Lidoderm is approved if:

- The patient has a diagnosis of postherpetic neuralgia
- The patient has a diagnosis of another form of peripheral neuropathy
- The patient has a diagnosis of other pain (non-neuropathic) and an occupational or clinical reason exists that other analgesics are contraindicated

*Coverage for other uses of Lidoderm is not approved.

Criteria approved through the DOD P&T Committee process February 2013

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TRICARE Management Activity,
a component of the Military Health System
DHHQ, 7700 Arlington Blvd,
Falls Church, VA 22042

Prior Authorization Request Form for

Lidocaine 5% patch (Lidoderm)

6009

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) TRICARE Mail Order Pharmacy (TMOP) *OR* the TRICARE Retail Pharmacy Program (TRRx). Express Scripts is the TMOP and TRRx contractor for DoD.

MAIL ORDER and RETAIL	• The provider may **call**: **1-866-684-4488** or the completed form may be **faxed** to: **1-866-684-4477** • The patient may attach the completed form to the prescription and **mail** it to: **Express Scripts, P.O. Box 52150, Phoenix, AZ 85072-9954** or **email** the form only to: **TpharmPA@express-scripts.com**

Prior authorization criteria and a copy of this form are available at: **http://pec.ha.osd.mil/forms_criteria.php.** This prior authorization has no expiration date.

Step 1

Please complete patient and physician information (please print):

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID # _____ Phone #: _____

Date of Birth: Secure Fax #:

Step 2

Please complete the clinical assessment:

1. Does the patient have a diagnosis of postherpetic neuralgia ?	☐ Yes Sign and date below	☐ No Proceed to Question 2
2. Does the patient have a diagnosis of another form of peripheral neuropathy?	☐ Yes Sign and date below	☐ No Proceed to Question 3
3. Does the patient have a diagnosis of other non-neuropathic pain?	☐ Yes Proceed to Question 4	☐ No STOP Coverage not approved
4. Is there an occupational or clinical reason that other analgesics are contraindicated?	☐ Yes Sign and date below	☐ No Coverage not approved

Step 3

I certify the above is true to the best of my knowledge. Please sign and date:

_____ _____

Prescriber Signature Date

[14 Aug 2013]